

SPECIMEN SUBMISSION FORM
 STATE LABORATORY INSTITUTE
 305 SOUTH STREET, JAMAICA PLAIN, MA 02130-3597
 Phone 617-983-6200

**Do Not Use
This Space**

PRINT, APPLY LABEL OR STAMP: DO NOT ABBREVIATE

ONLY ONE TEST PER SUBMISSION FORM

Send Results To: Facility / Laboratory Name (<i>required</i>)	Patient Information: Last Name, First Name, MI														
Address															
Phone #															
Ordering Provider and Phone #															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Patient ID</td> <td style="width: 50%;">Phone #</td> </tr> <tr> <td>Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other</td> <td>Date of Birth:</td> </tr> <tr> <td colspan="2">Race: (Check One)</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> American Indian or Alaska Native</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Black or African American</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Native Hawaiian or Pacific Islander</td> </tr> <tr> <td colspan="2">Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino</td> </tr> </table>		Patient ID	Phone #	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Date of Birth:	Race: (Check One)		<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Black or African American		<input type="checkbox"/> Native Hawaiian or Pacific Islander		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino	
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Test Requested: _____
 (required) One Per Form

Collection Date: _____
 (required) One Per Form

Serology			
Acute	Contact	Test of Cure	
Confirmation	Surveillance		
Convalescent	Symptomatic		

Culture			
Date of Culture:			
Date of Subculture:			
Sample Treated	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes, how:

Source of Specimen: (required) One Per Form

Anal canal	Nasopharynx	Stool	Body Fluid (site)
Blood	Plasma	Throat (pharynx)	Bronchus (site)
Bone Marrow	Serum	Urethra	Exudates (site)
Cervix	Spinal Fluid	Urine	Wound (site)
Gastric	Sputum		Tissue (site)
Other: (Specify)			

Additional Patient Information:

Symptoms, Date of Onset, and Duration
Travel History (Dates and Locations)
Animal / Insect contact: (specify)
Relevant Immunizations (Dates)
Previous Laboratory Results
Additional Information

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Please fill out “Additional Patient Information” section on front of form for the following tests:

Adenovirus	Herpes	Rickettsia
Arbovirus testing	Influenza	Respiratory Syncytial virus (RSV)
Babesia	Lymphocytic choriomeningitis virus (LCM)	Rubella
Campylobacter	Legionella	Salmonella
Chikungunya	Lyme Disease	Shigella
Cytomegalovirus (CMV)	Measles	St. Louis Encephalitis
Dengue Fever	Mumps	Syphilis
E. coli	<i>Mycoplasma pneumoniae</i>	Vaccinia virus
Eastern Equine Encephalitis	Parainfluenza	Varicella zoster
Enterovirus	Parasitology serology	Vibrio
Ehrlichia	Pertussis	West Nile Virus
Hantavirus	Q Fever	Yellow Fever